The armchair historian

Observations on the history of medicine and medical regulation

Medical Regulation and the Doctrine of Police Powers

NOVEMBER 28, 2017JULY 16, 2018 / DAVIDFSMB

Have you ever talked to a four year old about something they either couldn't or didn't want to understand? Remember their sing-song reply, "Why?"

Their persistence in responding to every explanation with that question could drive anyone to side with Sartre – "Hell is other people"

Not that I've had any four year olds asking me why we have medical regulation though some critics of our system do seem to have the intellectual willfulness of a child. For the benefit of those interested, I've considered the question ("Why do we have medical regulation?") from a historical/legal perspective.

Many of us understand the nature of the 10th Amendment; and if we thought about it, we'd recognize that a state granting a medical license to a physician rather than the federal government doing so seems like a concrete example of that amendment. So medical regulation is all about the 10th amendment, right? Not entirely.

What we tend to forget is an accompanying legal concept—the notion of "police powers" held and exercised by the individual states. The meaning and implications of both the 10th Amendment and this concept evolved through a series of court cases in the 19th century. Chief Justice John Marshall explicitly used the term in

Brown v. Maryland (1827) though, interestingly enough, the phrase "police power" does not appear in the Constitution and did not enter common parlance in legal circles until the 1880s.

Mention the phrase "police powers" to someone on the street today and they'll likely latch onto the word police and say this must have something to do with law enforcement. This misconception obscures the Founders' understanding and use of the concept. Revolutionary era leaders understood the term "police" as synonymous with the public polity, the community, civil administration and public order.

The concept of police powers evolved as a bulwark against federal incursion into state authority and decision-making. A series of important cases during John Marshall's tenure as Chief Justice of the U.S. Supreme Court confirmed this, e.g., *McCullough v. Maryland* (1819) and *Gibbon v. Ogden* (1824). In *Gibbon*, Marshall famously expanded on the division of federal and states powers with a tautology: "Enumeration presupposes something not enumerated." In other words, the fact that the Constitution lists specific powers for federal government—and those powers are limited to the things listed—means there must be other powers that are not listed which rest with the states.

What might these be? Marshall identified "inspection laws, quarantine law, [and] health laws" as examples of legislation "exercised by the States themselves." Three years later Marshall introduced the term "police power" explicitly in *Brown v. Maryland*, calling it an authority that "unquestionably remains…with the States."

While *Gibbon* dealt with interstate maritime commerce, it is not surprising that Marshall looked to a parallel area (health) as an example of state powers and their scope of authority. Colonial and later state governments during the early republic were accustomed to exercising a *de facto* regulatory function in the realm of public health. The population centers situated along transportation routes on rivers and coastal areas meant this country experienced frequent outbreaks and recurrences of epidemic diseases such as yellow fever, typhoid, cholera. A major yellow fever outbreak in Philadelphia and New York (1793-98) and recurrent cholera epidemics (1832, 1849, 1866) meant that local and state officials were accustomed to enacting emergency quarantine and other sanitary measures. Local authorities viewed these measures as justifiable actions designed to secure the public health by mitigating the effects of contagious disease.

The practical experience of local and state officials in dealing with health crises should not be overlooked when considering the advent of medical licensing laws and examining boards in the post-Civil War era. While many factors contributed to the rebirth of medical licensing in the second half of the nineteenth century, the experiences of state and local officials in dealing with health crises made it easier for the courts to view health matters as appropriate matters for state authority under the doctrine of police powers… and thus, an area that can and should be regulated.

Even before the seminal court case upholding medical regulation (*Dent v. West Virginia,* 1889), the U.S. Supreme Court recognized the practical and societal need for laws and regulations to guard the general public interest against the "few who…[would] imperil the peace and security of the many." (*Mugler v. Kansas*, 1887) This would be true whether the "few" were quack physicians or, in the case of *Mugler,* whiskey peddlers. The police powers doctrine meant the state could enact "measures…appropriate or needful for the protection of the public morals, the *public health* or the public safety." (italics added)

So if you find yourself sitting among physician colleagues and talking in general terms about medical regulation, feel free to impress them with your explanation of police powers and the 10^{th} amendment…and if you can inject the word "tautology" into the explanation, award yourself double bonus points.

The views expressed are those of the author and not those of the FSMB.

Sources

Santiago Legarre, "The Historical Background of the Police Power," *Journal of Constitutional Law* (February 2007): 778, 782.

Gibbon v. Ogden, 22 U.S. (9 Wheat.) 1, 203 (1824).

Brown v. Maryland, 25 U.S. (12 Wheat.) 419, 443 (1827)

Edward P. Richards, "The Police Power and the Regulation of Medical Practice: A Historical Review and Guide for Medical Licensing Board Regulation of Physicians in ERISA-Qualified Managed Care Organizations," *Annals of Health Law* 8:1 (1999): 203-204.

Charles E. Rosenberg, *The Cholera Years* (Chicago: University of Chicago Press, 1962) and Owen Whooley, *Knowledge in the Time of Cholera: The Struggle over American Medicine in the Nineteenth Century* (Chicago: University of Chicago Press, 2013) address quarantine measures

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The armchair historian

Observations on the history of medicine and medical regulation

The “lost” powers of state medical boards Part 1

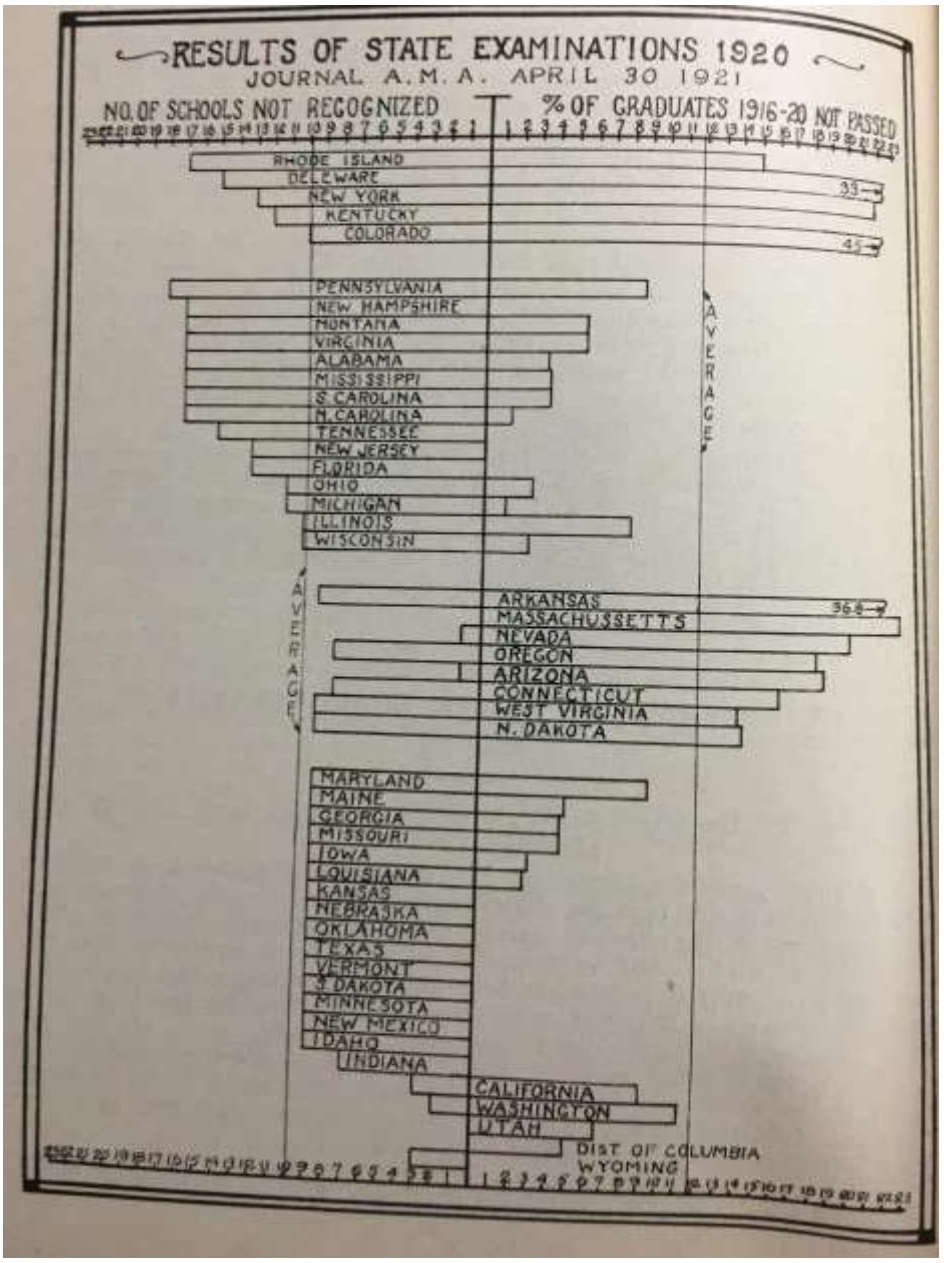
MARCH 16, 2018MARCH 26, 2018 / DAVIDFSMB

State medical boards operate under-the-radar of most physicians and the public at large despite the fact they have been integral players in the U.S. medical regulatory system since their appearance in the last quarter of the nineteenth century.

By any objective measure, however, state medical boards exerted their greatest power and influence nearly a century ago. I was reminded of this when I ran across this intriguing chart (below) from the June 1922 issue of the *Federation Bulletin.*

Take a closer look. The author of the article cobbled together statistics presented in *JAMA’s* annual report presenting statistics and information on the activities of state medical boards. The chart took a clever approach in consolidating two disparate pieces of information: state medical boards’ decisions to refuse licenses to graduates of certain schools and performance on their examination for medical licensure.

Let’s start on the left with state boards’ recognition of U.S. medical schools. With the exception of Massachusetts, Wyoming and the District of Columbia, every state board flagged a subset of schools that they refused to recognize for the purposes of licensing their graduates. Indeed, most of these boards identified 8-10 schools that they refused to recognize; nearly double that number in states like Pennsylvania and New Hampshire.



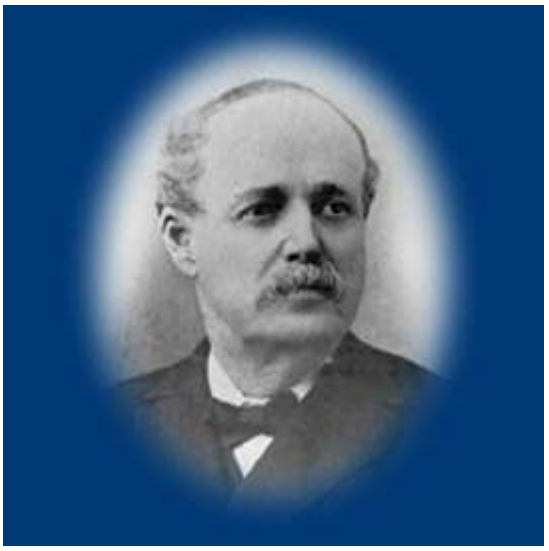
You’re probably wondering, “How was it possible someone could graduate from a US medical school and not be eligible for a license in most states?” To answer this question, we have to forget the medical education landscape as we know it in 2018.

We are so accustomed to the presence and function of trusted accrediting bodies for medical education (both undergraduate and graduate) that it’s easy to forget the realities of an earlier era.

In the first decades of the medical licensing (roughly the period from 1870 to 1910) there were no agencies or mechanisms providing assurance that anything substantive stood behind the issuance of a medical degree. At the time that state medical boards were established, they relied on generalized language (either in statute or developed by the board) that spoke in terms of licensing graduates of “reputable” or “legally chartered” schools.

Practical experience soon proved the uselessness of such language. A vague term like “reputable” offered little guidance and no measurable basis for distinguishing reputable from disreputable schools. Similarly, holding a legal charter was no guarantee. Even a medical diploma mill like the Eclectic Medical College of Pennsylvania held a valid, legal charter

Enter Dr. John Rauch and the Illinois Board of Health who quickly became the most influential players in the medical licensing community.



Rauch and his board colleagues embarked upon an ambitious information gathering effort that led to the first list of “approved” medical schools. A listing soon utilized by multiple states and claimed by several historians in recent years as being just as impactful as the later Flexner report.[1]

The American Medical Association (AMA) later took up the mantle of bolstering medical education standards with the creation of its Council on Medical Education. The Council undertook surveys and inspections in 1907-1908 that led to their own assessment of schools and a classification system. The Council classified medical schools into three groups. Schools of the highest quality were categorized as Class A; schools with deficiencies but still salvageable were categorized as Class B. The remainder (Class C) were deemed beyond the pale and believed to be unsalvageable.

By the time of the chart pictured here, medical boards were no longer as involved in investigating and monitoring the quality of medical schools. Instead, they drew upon the Council’s classification system to identify approved or recognized schools (Class A & B) and routinely deny licenses to graduates of Class C schools.

By the end of the 1920s, Class C schools had all but disappeared. Fast forward to 1942. This classification system evolved into the accrediting body that we know today for schools issuing the MD degree—the Liaison Committee for Medical Education (LCME).

Consequently, medical boards no longer have the need for formal lists of approved or recognized schools. The imprimatur of LCME accreditation assures medical boards of the meaningful education

experience behind an MD degree.[2]

I would argue that this “lost” power of medical boards is a good thing…a positive reflection of just how far medical education and licensing have come over the past century.

Next time (in Part 2), we’ll look at the right side of this chart and the other “lost” power of state medical boards—state board examinations.

The opinions expressed are those of the author and not the FSMB.

[1] See Lynn E. Miller, Richard M. Weiss, “Medical Education Reform Efforts and Failures of US Medical Schools, 1870-1930,” *Journal of the History of Medicine and Allied Sciences* (July 2008)

[2] The Commission for Osteopathic College Accreditation (COCA) accredits osteopathic medical education programs issuing the D.O. degree.

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Observations on the history of medicine and medical regulation

The “lost” powers of state medical boards Part 2

APRIL 2, 2018MAY 3, 2018 / DAVIDFSMB

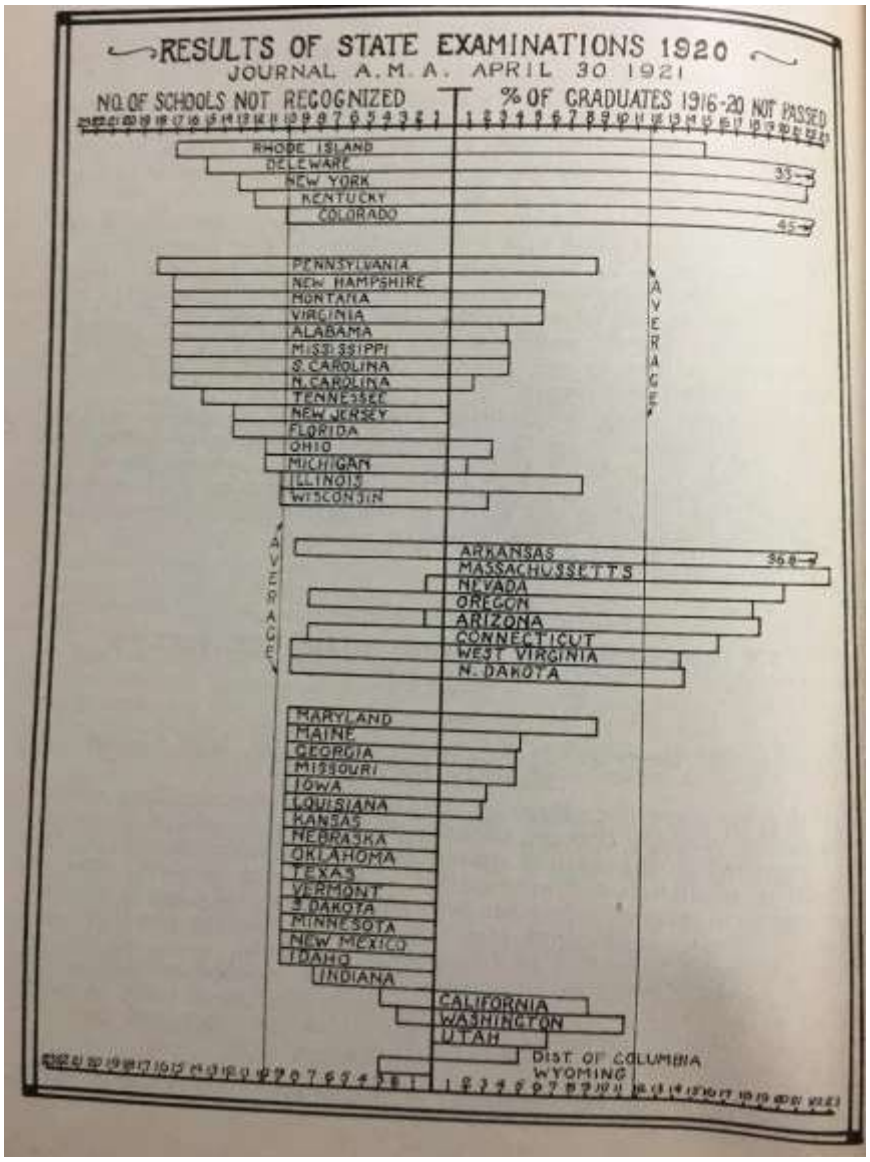
Last time I explained the authority of state medical boards to identify “approved” and “unapproved” medical schools as one criteria in the decision to issue or deny a medical license—one of the “lost” powers of state medical boards. The information presented on the left side of the chart below reflects this information.[1] Now let’s explore the other side of the chart.

Co-existing with the statutory authority of state boards to issue a license for the practice of medicine is their primary historical function—developing and administering an exam to determine the knowledge of a prospective licensee.

As noted earlier, the quality of U.S. medical schools varied widely in the late 19th and early 20th centuries. Thus, the medical degree could not be accepted at face value as definitive evidence of preparedness to practice medicine. Accordingly, state medical boards were empowered to independently assess the knowledge of prospective licensees.

State medical boards—or the *state board of medical examiners* to use the more common title of that era—embraced this assessment role. Their exams typically were multi-day affairs relying upon open-ended questions, i.e., extended short answer or essay questions.

Look closely at the right side of this chart; one element jumps out immediately. The fail rate on these exams differed dramatically



among the various states. At one end of the spectrum, sixteen states reported a fail rate of less than 1% on their licensing examination over the period from 1916-1920.

At first, I was suspicious whether this was accurate so I double checked the *JAMA* state board issues for this period. Sure enough, in places like Vermont and Idaho only 1-2 people failed during this entire period. Thus, a fail rate of less than 1% was accurate.

At the other end of this spectrum, five states reported fail rates of 22% or higher during this period. These weren’t all small states either. Heavily populated states like Massachusetts and Pennsylvania were in this cohort.

Furthermore, there didn’t seem to be a strong correlation between the number of schools not recognized by a state and the fail rate on its exam. Theoretically, we’d expect states like Delaware and Massachusetts to have lower fail rates because they already

precluded so many graduates from substandard schools from sitting their exam. Yet, their fail rates were actually quite high—33% and 23% respectively.

Similarly, we might anticipate a higher fail rate in places like Utah and the District of Columbia since they precluded no one from sitting their exam. Yet, their fail rates were modest (5-7%) and well below the national average.

All of which leads to a suspicion that state medical board exams of this era were idiosyncratic tools that diverged markedly not only in their rigor (i.e., pass/fail standard) but probably to some extent in their content as well.

It is no wonder that the National Board of Medical Examiners developed and administered a certifying exam beginning in 1916 with eligibility criteria and professional standards designed to meet and exceed those of every state board exam…and no wonder that thirty-one states by 1925 accepted a pass on this exam as meeting their requirements for licensure.[2]

State medical boards remained in the business of creating licensing examinations until the late 1960s when the transition to nationally developed exams began. I’ll talk about that transition later.

Technically, state medical boards have not “lost” the power of assessment. What has happened is a shift in statutory language reflecting these boards’ responsibility to identify the examination(s) they will recognize and accept as evidence of medical knowledge: USMLE and COMLEX-USA.

They have delegated (wisely) the daunting task of developing and administering their own medical licensing exam to professional entities with expertise in the science of assessment. In doing so, these boards retain their key role as an invaluable independent audit of medical education with their exam…but now they do so in concert with experts in assessment.

The opinions expressed are those of the author and not the FSMB.

[1] *Federation Bulletin,* June 1921, p.

[2] Johnson, Chaudhry. *Medical Licensing and Discipline in America,* 72.

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Observations on the history of medicine and medical regulation

Proxy Wars: A state board saga Episode 1: The Clone Wars

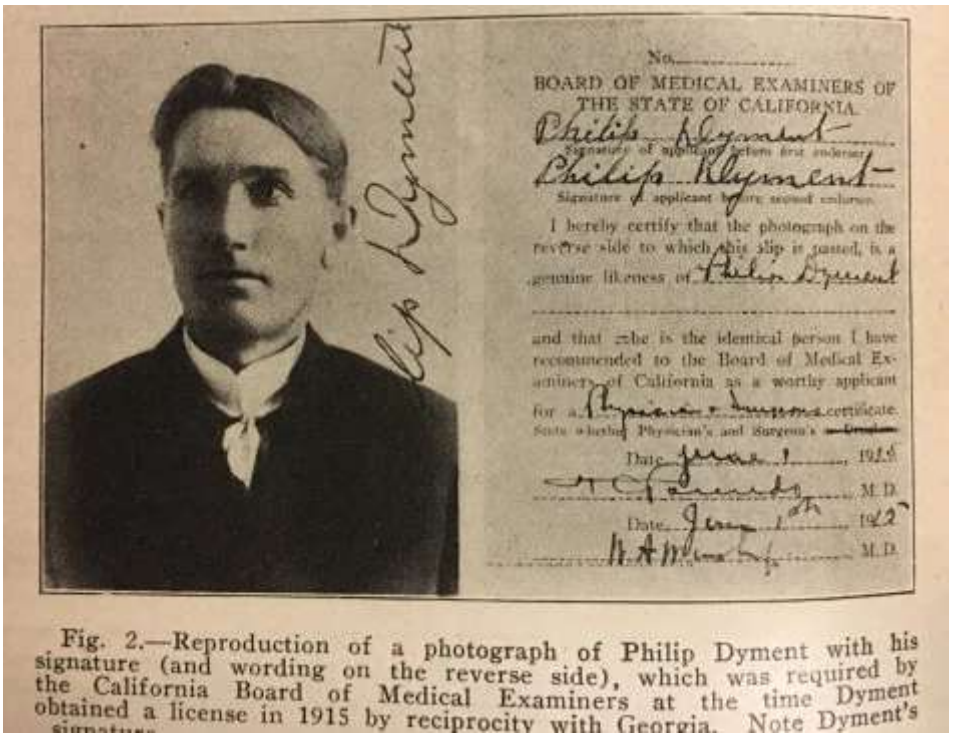
FEBRUARY 20, 2018FEBRUARY 20, 2018 / DAVIDFSMB

When state medical boards were being established throughout the United States in the last quarter of the 19th century, one of their primary statutory functions called for examining prospective candidates prior to issuing a license. This made sense as perhaps the greatest distinguishing feature of America's medical schools at that time was their wide variation in quality and rigor.

As the medical license became the exclusive gateway to the legal practice of medicine, the stakes surrounding each state's licensing exam grew higher. Some physicians were unwilling to accept the challenge to demonstrate their knowledge. Others—likely a small number—resorted to subterfuge, i.e., using proxy or substitute or ringer to take the exam for them. Case in point – "Dr." Phillip Dyment.

Dyment's factual record seemed straightforward. He graduated from the Homeopathic Medical College of Missouri. In 1914, the Georgia Board of Medical Examiners issued him a license after passing their requisite exam. The following year, 1915, Dyment obtained a license in California (below) through a reciprocity certificate issued based upon his Georgia exam and license.

For reasons that are not entirely clear, staff working in the AMA's Biographical Department took a closer look at Dyment's record trail in 1919. Several items jumped out at them.



No.....

BOARD OF MEDICAL EXAMINERS OF THE STATE OF CALIFORNIA

Philip Klyment

Signature of applicant before first endorser

Philip Klyment

Signature of applicant before second endorser

I hereby certify that the photograph on the reverse side to which this slip is pasted, is a genuine likeness of Philip Dyment

and that he is the identical person I have recommended to the Board of Medical Examiners of California as a worthy applicant for a Physician's & Surgeon's certificate. State whether Physician's and Surgeon's ~~or Osteopath~~

Date June 1 1915

M. D.

Date June 1st 1915

M. D.

Fig. 2.—Reproduction of a photograph of Philip Dyment with his signature (and wording on the reverse side), which was required by the California Board of Medical Examiners at the time Dyment obtained a license in 1915 by reciprocity with Georgia. Note Dyment's signature

(1) Dyment graduated from medical school in 1891 but did not secure a medical license until his 1914 in Georgia. So what had he been doing all those years prior? Not practicing as a physician apparently. In a 1909 advertising flyer prepared by Dyment, he described himself as practicing "Mechano-Therapy." Nowhere in the flyer did he claim an M.D. (see below right)

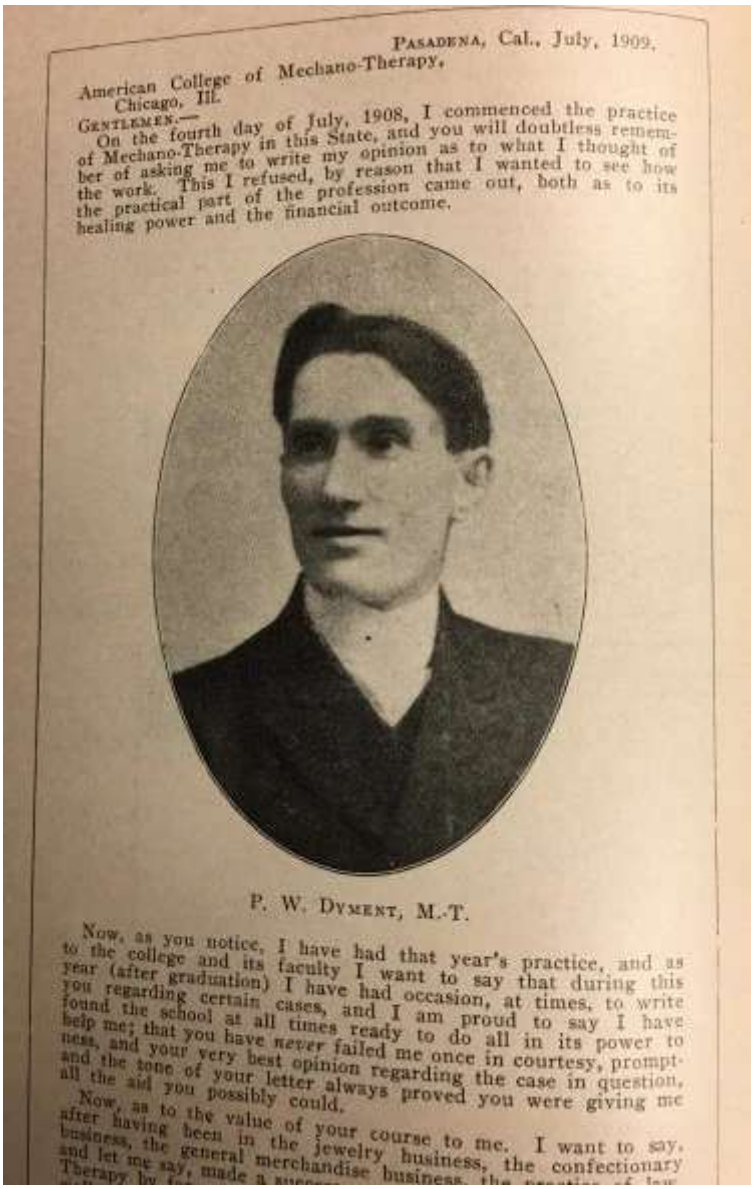
(2) The Homeopathic College from which he claimed to have graduated had a suspect history. In a 1918 publication, the AMA listed the school as a fraudulent" institution—a classification applied to institutions that operated outside even the relatively loose parameters for diploma issuance in the late 19th century.

(3) Inquiries through two of the school's registrars and one of its trustees suggested that Dyment never attended, much less graduated, from the school.

(4) The only person associated with the school who substantiated Dyment's claim to being a graduate was a former dean of the school, Dr. L. C. McElwee. As early as 1908, however, McElwee had been implicated in issuing a certificate to an unsuccessful applicant for licensure in Illinois, Dr. G. B. B. Larkeque.

So how did Phillip Dyment transition from mechano-therapist (i.e., chiropractor) to physician? With a little help from his friends, of course.

Investigation by the Georgia board revealed that Dyment (via Larkeque) secured the services of Dr. Lucius G. Wright to sit the examination for Dyment at the board's offices in Atlanta, Georgia in the fall of 1914. McElwee's substantiation of Dyment's claim of an



PASADENA, Cal., July, 1909.

American College of Mechano-Therapy,
Chicago, Ill.

GENTLEMEN:—

On the fourth day of July, 1908, I commenced the practice of Mechano-Therapy in this State, and you will doubtless remember of asking me to write my opinion as to what I thought of the work. This I refused, by reason that I wanted to see how the practical part of the profession came out, both as to its healing power and the financial outcome.

P. W. DYMENT, M.-T.

Now, as you notice, I have had that year's practice, and as to the college and its faculty I want to say that during this year (after graduation) I have had occasion, at times, to write you regarding certain cases, and I am proud to say I have found the school at all times ready to do all in its power to help me; that you have *never* failed me once in courtesy, promptness, and your very best opinion regarding the case in question, and the tone of your letter always proved you were giving me all the aid you possibly could.

Now, as to the value of your course to me. I want to say, after having been in the jewelry business, the confectionary business, the general merchandise business, the practice of law and let me say, made a success[illegible] Therapy by [illegible]

M.D. likely reflected his role in brokering the aid of Larkeque and Wright –both of whom traveled to Atlanta for the exam.

Wright received $150 for his efforts in taking (and passing) the exam on Dyment's behalf. Larkeque's role apparently involved doctoring photographs and signatures involved with the licensing application in Georgia. The key evidence in the case came from a deposition secured by Wright's [disgruntled?] wife. (see below)

It is impossible to know whether the Dyment case was an extreme outlier or just one example of a practice more prevalent that one might have imagined. Certainly, medical boards feared exam proxies and worked to establish elaborate protocols designed to forestall such tactics.

The minutes from a meeting of the North Carolina medical board in 1889 captured one of its "rules" pertaining to exam administration. These included a signed written oath by the applicant that he had "neither given nor received" exam information; and that he had not "used any unfair means" to pass the exam. In the aftermath of the Dyment case, California board secretary, Dr. Charles Pinkham, wrote extensively on "safeguards" to the medical examination and licensing systems.

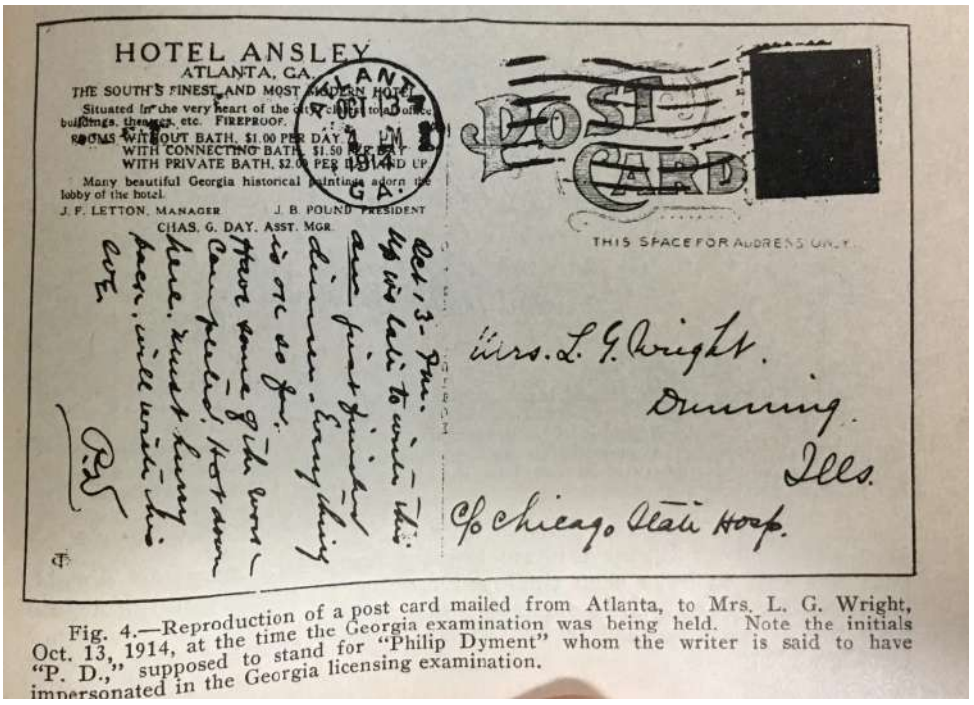


Fig. 4.—Reproduction of a post card mailed from Atlanta, to Mrs. L. G. Wright, Oct. 13, 1914, at the time the Georgia examination was being held. Note the initials "P. D.," supposed to stand for "Philip Dyment" whom the writer is said to have impersonated in the Georgia licensing examination.

As for Dyment? In 1920, the California and Georgia medical boards revoked the licenses issued to him. End of story, right? Not quite.

I'll share the rest of the Dyment story next time. I think I'll call title it: "Episode 2: The Imposter Strikes Back."

The opinions expressed are those of the author and not the FSMB.

Sources:

"Secured Licenses by Fraud," *Federation Bulletin* 5, no. 10 (October 1919): 223-29

Charles Pinkham, "Safeguards Against Impositions in State Board Examinations," *Federation Bulletin* 7, no. 8 (August 1921): 178-81.

Medical Colleges of the United States and of Foreign Countries (Chicago: American Medical Association, 1918)

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The armchair historian

Observations on the history of medicine and medical regulation

Proxy Wars Episode 2: The imposter strikes back

FEBRUARY 26, 2018FEBRUARY 21, 2018 / DAVIDFSMB

Episode one closed with the California and Georgia medical boards stripping "Dr." Phillip Dyment of his medical license. The good doctor was nothing, however, if not persistent. Like any good charlatan, he lawyered up. Today, we conclude the story of "Dr" Dyment but first a little context.

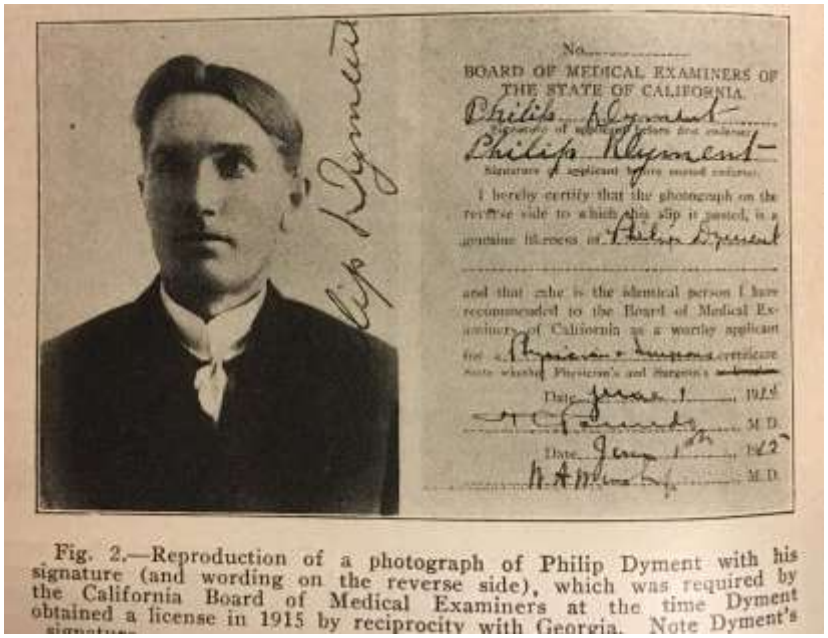


Fig. 2.—Reproduction of a photograph of Philip Dyment with his signature (and wording on the reverse side), which was required by the California Board of Medical Examiners at the time Dyment obtained a license in 1915 by reciprocity with Georgia. Note Dyment's

In 1920, state medical boards were quasi-legal entities straddling two spheres. On the one hand, they served as an extension of the state (i.e., government). In *Dent v. West Virginia* (1889) and *Hawker v. New York* (1898), the U.S. Supreme Court accepted the authority of the state (or one of its agencies) to

"provide for the general welfare of its people" in matters of public health. Specifically cited was the authority of the state to license and/or examine physicians for the practice of medicine.

On the other hand, state medical boards were bodies heavily weighted toward the interests of physicians and the medical profession in general. Gubernatorial appointment may have been the mechanism for inclusion on these boards but state medical associations exerted tremendous influence by identifying or recommending appointees to these exclusively physician boards. (Note: public members were non-existent at the time)

I share this because legal challenges arose almost as soon as the first medical board issued a decision to issue or revoke a license. Medical boards quickly found themselves on the receiving end of a crash course: *Intro to Law 101*. Because they operated with a fair degree of autonomy and often lacked access to in-house counsel, medical boards were sometimes outflanked by savvy physicians quick to lawyer up and exploit legal missteps.

Though he was a fake, Dyment proved a savvy fake.

Having learned from the Georgia board about Dyment's use of a proxy/ringer on their licensing exam, the California medical board notified Dyment in August 1920 of their complaint against him for "unprofessional conduct." The board demanded he appear before them in October to answer the charge. Apparently operating from a parental rather than a legal mindset ("You know what you did, young man!"), the board didn't bother to list any detail in its complaint for unprofessional conduct.

Dyment (through his attorney) spotted the board's error immediately. Instead of appearing before the board in October, he replied with a letter of his own. The legal term for his responding letter is a demurrer but what it comes down to really is this: Dyment said he could not answer the charge—and had no legal obligation to do so—because the board had not been "sufficiently definite and specific" by explaining which of the twelve statutory bases for unprofessional conduct that he had violated.

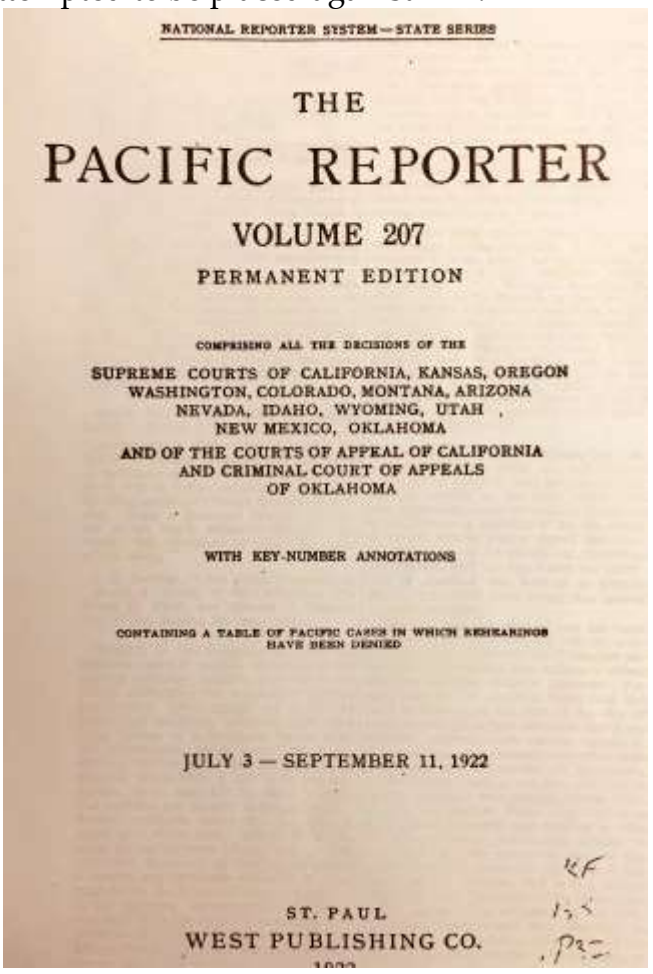
At its hearing in October *sans* Dyment, the board decided to ignore the point of law raised by Dyment. They had nothing in their regulations about responding to demurrers so they opted to proceed based upon the facts of the case as they understood them. The board found Dyment guilty of unprofessional conduct and revoked his license.

Dyment took this decision and ran to the courts. A California Superior Court sided with the medical board—apparently citing the board's enacting regulations as not providing for demurrers.

Having lost the first two rounds, an unbowed Dyment pressed on to a state appellate court. Here he found success.

The appellate court reversed the decision stating the fundamental right of a citizen that a complaint against them be sufficiently definite and specific that they can respond adequately to the charge. The court stated that the medical board erred by not first addressing Dyment's demurrer (the insufficiency of the complaint) before proceeding with its hearing on the facts of the case.

Having said all this, the appellate court acknowledged the valuable work of the medical board. "The work done by the medical boards…in purging the ranks of the medical profession of quacks and charlatans is a most commendable one." This, however, did not outweigh the board's legal responsibility to "notify [Dyment] of the nature of the offense attempted to be placed against him."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Rebuked but not discouraged, the California medical board went after Dyment again—this time sufficiently setting forth the details of the complaint. Again after a hearing, the board revoked Dyment's license.

Dyment struck back on two points of law that did not conclude until 1928. First, Dyment claimed that the board operated in a "quasi-judicial" capacity and that evidence of bias on the part of one of the board members violated California law requiring judges with bias or interest in a matter to recuse themselves. The court disagreed citing previous case law that a state medical board served an "administrative" rather than judicial function; thus, the law was not applicable in this case.

On his second point, Dyment found success. He claimed the only evidence against him (the affidavit of the proxy test taker wife) was hearsay. While the court acknowledged that the substance of the

evidence may have been true, its form (hearsay) was not admissible; and lacking other evidence that did not constitute hearsay, the appellate court once again ruled in favor of Dyment.

This case offers a great example of the many difficulties facing state medical boards of this era. They may have been quasi-judicial bodies serving an administrative role but the legal system held them accountable for observing procedural and substantive due process. Not surprisingly, physicians on these boards floundered at times in navigating unfamiliar legal waters.

And "Dr" Phillip Dyment? The last I found of him dates to 1929… he was still practicing medicine in California.

The opinions stated here are those of the author and not that of the FSMB.

Sources:

Dyment v. Board of Medical Examiners, 93 Cal. App. 65. 268 P. 1073

The Pacific Reporter, 207, July 3-September 11, 1922 (St. Paul: West Publishing Co., 1922), 410-12

"Phillip Dyment Still Practicing," *Federation Bulletin* 15, no. 6 (June 1929), 190.

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The armchair historian

Observations on the history of medicine and medical regulation

Some Origins of State-based Medical Regulation

NOVEMBER 20, 2018 / DAVIDFSMB

In the years following the American Civil War (1861-65) multiple states and territories passed laws to regulate and limit the practice of medicine—specifically, requiring individuals to meet criteria set by the designated state entity (e.g., state board of medical examiners) and obtain a license before practicing medicine. Half a dozen states established medical licensing boards by the end of the 1870s, another dozen were established in the 1880s and most remaining jurisdictions did so in the 1890s.

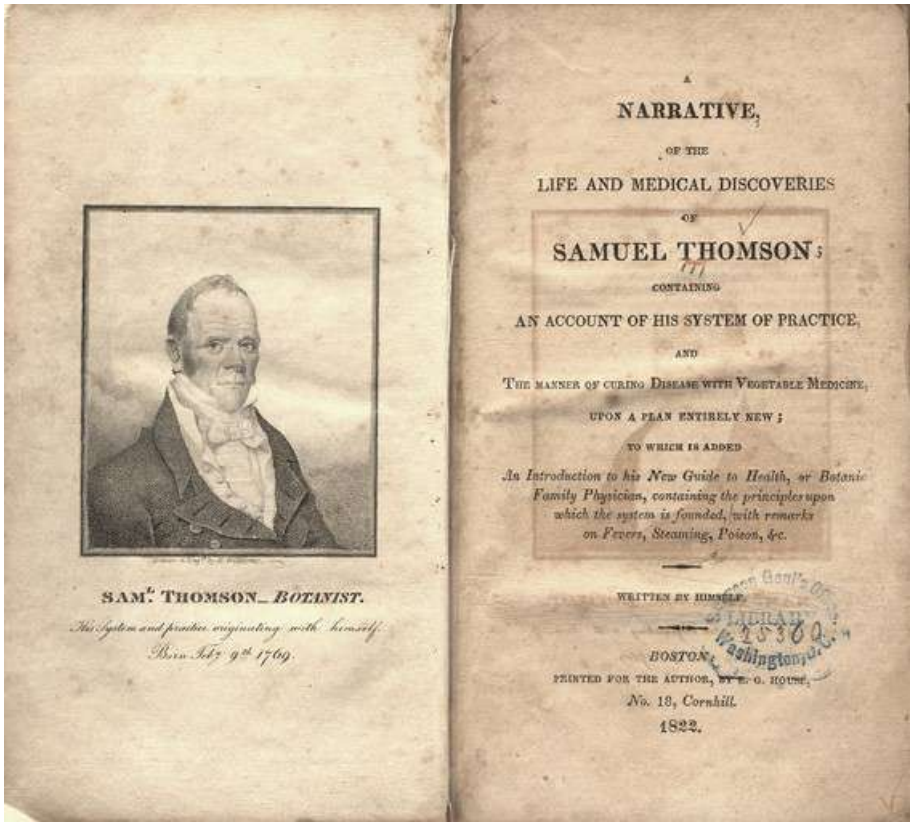
For those with any familiarity on the subject, there is nothing new in what I just shared. The "when" in this evolving regulatory system can be presented in a straightforward chronology presenting the introduction of medical practice acts and the establishment of state medical boards.

However, the question of "why" is a different story. Specifically, why did state-based medical regulation emerge at that particular moment in America's history? People had been practicing medicine long before any state laws regulating the practice—so why did the state legislatures suddenly feel it necessary to begin regulating medicine?

Here we enter speculative grounds but I would offer several reasons for the emergence of medical regulation in the post-Civil War era.

Push back against the "democratization" of medical care

In 1822, the New England folk healer Samuel Thomson published his *"New Guide to Health; or Botanic Family Physician."* This modest beginning marked the start of Thomson's widely successful efforts to re-establish the practice of medicine with its rightful practitioners and *materia medica*—specifically, family and friends drawing upon herbal or botanic-based remedies. Thomson's success with direct to consumer guidebooks for medical practice and agents in the field selling his "system" of botanical remedies resonated deeply with Americans of that era increasingly adverse to privilege and hierarchy.



SAM.L THOMSON. *BOTANIST.*

His System and practice originating with himself

Born July 9th 1769.

A

NARRATIVE,

OF THE

LIFE AND MEDICAL DISCOVERIES

OF

SAMUEL THOMSON;

CONTAINING

AN ACCOUNT OF HIS SYSTEM OF PRACTICE,

AND

THE MANNER OF CURING DISEASE WITH VEGETABLE MEDICINE,

UPON A PLAN ENTIRELY NEW;

TO WHICH IS ADDED

An Introduction to his New Guide to Health, or Botanic Family Physician, containing the principles upon which the system is founded, with remarks on Fevers, Steaming, Poison, &c.

WRITTEN BY HIMSELF.

BOSTON:

PRINTED FOR THE AUTHOR, BY E. G. HOUSE,

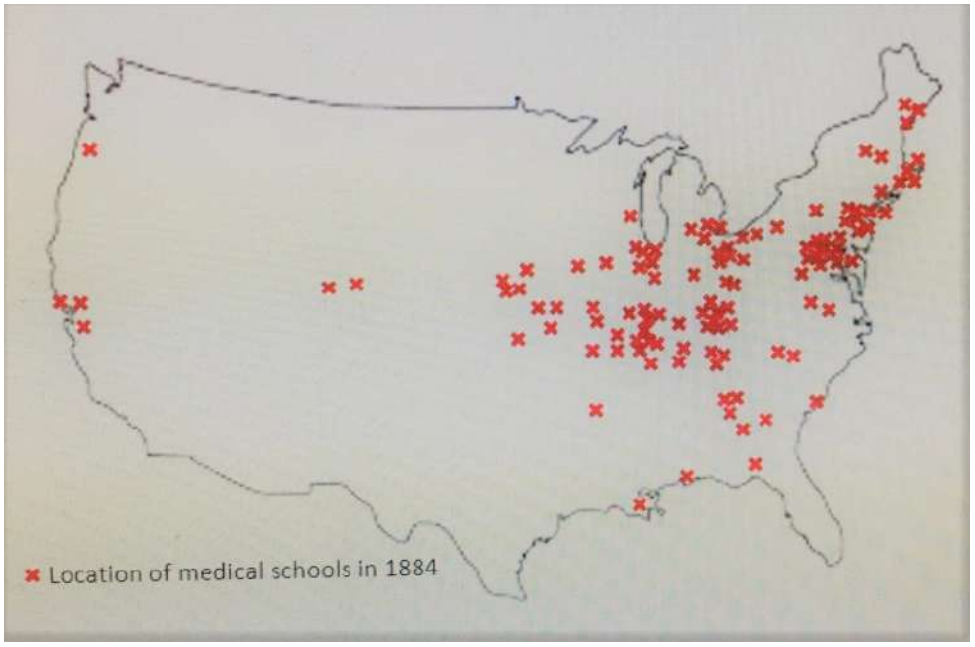
No. 18, Cornhill.

1822.

Thomson's success irked physicians (no surprise!) who felt their knowledge and skill denigrated by home practitioners. When the home medicine-tide finally began to ebb in the post-Civil War era, physicians were already organized (i.e., AMA and state medical societies) and poised to push back. Physicians could point to major advances ongoing in medicine as a basis for establishing themselves as *professionals* with exclusive control over the practice of medicine. Staking out and securing their "turf" legislatively, including controlling entry into the profession, became a priority for physicians.

Explosive growth in the number of medical schools

At the opening of the 19th century, there were a handful of medical schools in America. By mid-century, there were 50 medical schools. By 1884, there were approximately 100 schools.



Weak chartering laws and the didactic nature of US medical education meant that all that was required to establish a medical school was a building, a minimal amount of materials (books, lab supplies, access to cadavers) and a handful of physicians willing to collaborate as faculty. The result was a sharp increase in the number of individuals holding an actual medical degree and eager to seek a financial return on their modest investment through practicing medicine. Just as important, this era predates even *de facto* accreditation efforts. Consequently, wide variability in quality characterized US medical education.

From a demographic and educational perspective, this situation posed serious challenges for US physicians seeking to establish medicine as a legitimate profession. To use a metaphor, medical schools were like a faucet with a broken handle gushing forth newly-degreed physicians. It was impossible to cut off the flow; but if one attached new piping to the opening of the faucet, it would be possible to reduce the flow. The "new piping" was state legislation setting forth criteria for the legal practice of medicine and a designated authority (state medical board) empowered to evaluate individual qualifications and issue licenses. Statutory requirements could be set in such a way as to either restrict or encourage the flow of graduates from medical schools. Organized medicine worked doggedly toward restricting the flow.

Rise of the penny press newspaper

Medical societies and individual physicians had another stalking horse at their disposal in arguing for a medical practice act in their state –the quack[1] or the charlatan. Hawkers of medical cures and remedies can be traced into the Middle Ages where they often combined medical, theatrical and itinerant elements. With so many, at best, modestly educated practitioners pouring out of American

medical schools—including those with degrees from schools little more than medical diploma mills—the medical establishment could point to outlier practitioners (conveniently labeled quacks or charlatans) as a tangible example of the need for medical legislation.

Their case was further bolstered by the ready availability of cheap print advertising in the daily penny press newspapers. Wild claims involving all manner of lotions, potions, pills, nostrums and elixirs filled newspapers, short-lived medical journals and circulars. Physicians could point to the over-the-top claims in these ads from outlier practitioners as proof of a danger to the public.

I would argue that all three forces were at work in the post-Civil War years; combining in a mutually reinforcing way that resulted in a steady push toward a state-based system of medical regulation.

The views expressed are those of the author and not the FSMB.

Resources:

William G. Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore: Johns Hopkins Univ. Press, 1985)

John S. Haller, Jr., *The People's Doctors: Samuel Thomson and the American Botanical Movement, 1790-1860* (Carbondale: Southern Illinois Univ. Press, 2000)

M. A. Katritzky, "Marketing Medicine: The early modern mountebank," *Renaissance Studies* 15, no. 2 (2001).

[1] Quack derives from the Dutch *quacksalver* meaning a hawker of salves.

Uncategorized